Family/Medical Leave Form

(Family Medical Leave Act of 1993)

Name: _____ County Court: _____

Work Address: _____ Probation Office: _____

_____ Other: _____

Immediate Supervisor: _____

Reason for Family/Medical Leave:

- ☐ Birth of my child. The child's birth date or expected birth date is _____.
- ☐ I am adopting a child. The date of the child's placement was/is_____.
- ☐ Placement of a foster child in my home. The date of the child's placement was/is _____.

Note: Circumstances may require that leave for the birth of a child or for placement for adoption or foster care, be taken prior to the actual birth or placement. Family leave absence must be completed no later than one year after the child's birth, adoption, or foster care placement.

- ☐ Care for seriously ill mother or father.
- ☐ Care for seriously ill spouse.
- ☐ Care for seriously ill child.
- ☐ Care for my own serious illness or injury.

Note: In each case above, serious illness requires either inpatient care or continuing treatment by a health care provider. Also, a Physician's Certification Form must be completed and returned within 15 days of submission of this form.

In cases where family/medical leave can be anticipated, I understand I must complete this form a minimum of 30 days in advance. Where family/medical leave cannot be anticipated, I understand it is my responsibility to complete this form as early as possible and practicable.

My first day of absence from work will be _____ and I will return to work on _____.

Note: Total absence may not exceed twelve weeks. In cases of childbirth, adoption, or foster child placement, the employee may be required to take leave in a single continuous period. In cases of serious illness, leave may be taken intermittently for medical reasons according to a schedule approved by the physician. (Attach leave schedule to the Physician's Certification Form.)

(Continued on reverse . . .)

I understand that I will be required to use my accumulated compensatory time and my earned sick leave concurrently with Family/Medical Leave. After I have used all my earned sick leave and compensatory time, if I choose, I may use my earned vacation leave. If my paid leave is not sufficient to cover my entire Family/Medical Leave absence, the balance of the absence will be unpaid time off from work.

I understand that sick and vacation leave will not accrue and holidays will not be compensated during non-paid absences.

I understand that my service date will be adjusted if my unpaid absence exceeds fourteen consecutive calendar days.

I understand that I must complete the *Insurance Continuation Form* and include such form with this request if I need to go on unpaid leave.

I understand that I may not be allowed to return earlier than the above return to work date.

I understand I forfeit rights to my job if I fail to return to work on the above return to work date.

I understand that when I return to work, I will be returned to the same job I left.

Employee Signature: _____

Date: _____

Return to: **Judy Beutler, Deputy State Court Administrator**
Administrative Office of the Courts/Probation
P. O. Box 98910
Lincoln, NE 68509-8910
402-471-2921

----------FOR AOC USE----------

☐ *Response sent on* _____

☐ *Received Physician's Certification Form*

☐ *Received Insurance Continuation Form*

☐ *Copies sent to* _____, _____ & _____